

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035484

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 97

STATE FILE NUMBER

FILED OCT 10 1963

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u>		c. CITY OR TOWN <u>Cameron</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b <u>7 yr's</u>		d. STREET ADDRESS (If outside, give location) <u>118 So Elm</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Comm Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alma</u> Last <u>Caley</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19 1883</u> 80yr's
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11a. BIRTHPLACE (City and state or country) <u>Johnson Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James Caley</u>		13b. MOTHER'S MAIDEN NAME <u>Mary J. Curtis</u>	
14. NAME OF HUSBAND OR WIFE <u>Florence Caley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT Address <u>Florence Caley Cameron Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>arteriosclerotic heart disease</u> DUE TO (b) <u>10 yrs.</u> DUE TO (c) <u>48 hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>1:30</u> a.m. <u>2</u> p.m. <u>3</u> Month, Day, Year <u>4-11-1956</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Delano</u>		20f. CITY, TOWN, OR LOCATION <u>Cameron</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>4-11-1956</u> to <u>10-4-63</u> and last saw her alive on <u>10-3-63</u> . Death occurred at <u>6:05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>St. Hetherington MD</u>		22b. ADDRESS <u>Cameron Mo.</u>	
22c. DATE SIGNED <u>10-7-63</u>		23a. BURIAL, CREMATION, REINTERMENT (If not, state why) <u>Oct. 6 1963</u>	
23b. DATE <u>Oct. 6 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Delano</u>	
23d. LOCATION (City, town, or county) <u>Cameron</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Poland Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 7 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Francis D. Crawford</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

VS 300  
Rev. 4/59

1 0251

2 0251

3 2

4 0

5 1

6 0

7 0

8 0

9 4200

10 1-0

11 2-0

12 1-0

13 2-0

DATE AMENDED

ITEM NO.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Laurence J. Thompson

Licensed Embalmer No. 4735

P. O. Address Compton, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.